physicians requires clarification about the status of a proposed project on physician prescribing by the CMA and the Pharmaceutical Manufacturers Association of Canada. Although the CMA approached Drs. Davidson and D. William Molloy for assistance in exploring the feasibility of such a project, and Davidson and Molloy subsequently developed a proposal, the proposal was never "accepted" by the CMA, and the CMA never assured the researchers that the study would be funded.

The proposal was interesting, but it contained some methodologic problems. The investigators have not resolved the problems, and, thus, the project is not proceeding, but for a reason unrelated to the relationship between the New Brunswick Medical Society and the investigators. In addition, the CMA's approval of any project requires support from the provincial or territorial division involved. Because this support seems unlikely for a project headed by Davidson and Molloy in New Brunswick the proposal will not be implemented with the CMA's approval.

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Cost of midwifery

The article "Doctors' reactions mixed as midwives enter health care mainstream in Ontario" (*Can Med Assoc J* 1994; 150: 730–732, 734), by Lynne Sears Williams, surprised no one but Jane Kilthei, president of the Association of Ontario Midwives, who is mentioned in the sidebar "Midwife defends midwifery's cost" (page 731). Her statements "We've just begun [to examine the cost-effectiveness of midwifery]" and "What we need is research" are misleading and inaccurate.

In this day of hospital cutbacks and fee rollbacks, paying midwives a salary of $52 580 or more for normal deliveries is shocking and discriminatory toward all physicians. In Ontario family physicians and obstetricians receive $360 ($600 less 40% for office overhead) for a normal delivery, whereas midwives receive about $1314 (40 births at a salary of $52 580). In addition, because two midwives must be present at every birth the cost is raised to $2629 per birth.

If ever a case for pay equity existed this one fits the bill!

Earl Dobkin, MD
Willowdale, Ont.

[Ms. Kilthei responds:]

Dr. Dobkin makes the common mistake of dividing a midwife's salary by his or her caseload and comparing the result with a physician's fee-for-service earnings for pregnancy and childbirth, which is like comparing apples and oranges. A midwife carries out not only the primary care functions performed by the physician but also the education, counselling, support and monitoring functions commonly considered part of nursing care. Midwives, who are on call 24 hours a day, 7 days a week, travel to women's homes to provide care during labour and after the delivery. Each pregnant woman receives between 40 and 50 hours of care, including the care provided by a second midwife who attends the birth.

A midwife's nominal workweek is 44 hours, although in reality it seems more like 50 to 60 hours. The midwife makes about the same hourly wage as a nurse providing care during labour and delivery.

As for cost-effectiveness we know from studies in jurisdictions other than Ontario that rates of intervention are low in midwife-attended births, with no attendant increase in rates of perinatal mortality or morbidity.[1-3] In Ontario the use of analgesia, anesthesia and forceps as well as the rates of episiotomy and cesarean section — procedures that increase costs — have been found to be low in midwife-attended births.[4,5] As well, midwives tend to order ultrasonography less often, bring women into hospital at a later stage of labour and discharge women sooner than most physicians.[6] Midwife-attended home births provide the least expensive maternity care option. In addition, midwifery care has been associated with increased success with breastfeeding and decreased numbers of preterm and low-birth-weight babies.[7]

We expect midwifery to be one of the most closely examined areas of health care in Ontario, and we welcome that scrutiny. I especially look forward to research that focuses on some of the more complex issues related to long-term outcomes.

I am proud to be part of Ontario's health care system. We have achieved good outcomes in this province with the physician–nurse model of maternity care, and many women will continue to choose that model for their pregnancy care. Midwives offer women new options, and we believe that we can make a valuable contribution without negating the roles of other health care providers. We want to work in a spirit of cooperation and collegiality, and we hope that other care providers will meet us in the same spirit.

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References

1. Schimmel L, Hogan P, Boehler B et al: The Yolo county midwifery service: a descriptive study of 496 singleton birth outcomes, 1990. *J Nurse Midwifery* 1992; 37: 398–403
2. Stewart RB, Clark L: Nurse–midwifery practice in an in-hospital birthing center. *J Nurse Midwifery* 1982; 27: 21–26
3. Platt LD, Angeline DJ, Paul RH et al: Nurse–midwifery in a large teaching hospital. *Obstet Gynecol* 1985; 66: 816–820
4. Reid AJ, Galbraithe JG: Midwifery in a family practice: a pilot study. *Can Fam Physician* 1988; 34: 1887–1890
5. Tyson H: Outcomes of 1001 midwife-attended home births in Toronto,